Department of Medical Assistance Services
Division of Long-Term Care
Money Follows the Person (MFP)

Frequently Asked Questions and Answers

These frequently asked questions were derived from the MFP Transition Coordination training sessions held April 30 and May 14, 2008. Additional questions may be submitted to mfp@dmas.virginia.gov.

Money Follows the Persons Project

This four year project, funded by federal and state sources provides participants of all ages and all disabilities who live in institutions(nursing facilities, Intermediate Care Facilities for Individual with Intellectual Disabilities/Mental Retardation and long-stay hospitals) in the Commonwealth of Virginia options to transition to home-and-community based settings.

Transition Coordinator
This is the Department of Medical Assistance Services (DMAS) provider who is responsible for supporting the individual and family/caregiver, as appropriate, with the activities associated with transitioning from an institution to the community. Service descriptions, criteria, service units and limitations and provider requirements for the service are found in 12 VAC30-120-2000.

Transition Coordination

Transition Coordination is the management and coordination of the transition of a participant from the institution to the community. Transition Coordination is exclusively for the EDCD waiver. Transition Coordination is limited to 15 months from date of prior authorization.

Transition Coordination is provided by a case manager in the MR/ID, DD and Tech waiver.

Question 1: Who was invited to the training on Money Follows the Person?

Answer: The invitations for the training went to current Medicaid provider agencies, for the purposes of providing an overview for agencies and communities on MFP and for recruiting Transition Coordination agencies.

Question 2: What agencies can become Transition Coordination agencies?

Answer: Transition Coordination agencies (agencies that employ a transition coordinator) shall be employed by one of the following: a local government agency, or a private, nonprofit organization qualified under §26 USC 501 (c) (3).

Question 3: Can Area Agencies on Aging be Transition Coordination agencies?

Answer: Yes, if they are a local government agency or a private nonprofit organization qualified under §26 USC 501 (c) (3) and enrolled as a Medicaid provider of Transition Coordination.

Question 4: Are there any limits to the number of enrolled Transition Coordination agencies under MFP?

Answer: No

Question 5: If a participant is enrolled in the Elderly or Disabled with Consumer-Direction (EDCD) waiver may a Community Services Board case manager serve as the Transition Coordinator?

Answer: Yes as long as the CSB has enrolled with Medicaid as Transition Coordinator and meets all applicable requirements.

Question 6: How will Transition Coordination agencies come into contact with residents?

Answer: A multifaceted approach through marketing is envisioned for MFP. Transition Coordination agencies will be encouraged to advise facilities, families, etc. of the agency's enrollment as a Medicaid provider agency for transition services. Transition Coordinators may visit the local nursing facilities, intermediate care facilities and long-stay hospitals to work with the administration in identifying persons eligible for successful enrollment in the MFP program.

Question 7: What is the difference between services provided through MFP and the current waivers as it relates to case management?

Answer: Regarding case management or Transition Coordination, there is no difference. For EDCD, the Transition Coordinator will perform basic functions of the case manager for up to 12 months. This service is new, and we are currently recruiting agencies to enroll to provide Transition Coordination to EDCD recipients. For MR, the current case management system will function as the vehicle for service plan development. For Developmental Disabilities (DD)and the Technology Assisted (Tech) Waivers, each will use the current system for case management/oversight.

Question 8: If an eligibility worker from the local department of social services has a participant express an interest in leaving a facility who should they be referred to?

Answer: The eligibility worker should discuss this with the facility and the discharge planner and then refer the person and the discharge planner to the DMAS website for a listing of Transition Coordinators.

Question 9: Who will make the final decision related to enrolling in MFP?

Answer: This program is person centered, meaning that the individual or responsible representative will be the decision maker related to care and service type. All home- and –community- based waiver services require that service be provided to support health and safety of the participant. Ultimately, it will be the Transition Coordinator and/or the Case Manager in consultation with the person transitioning that will determine that the program is a good match, and by enrolling the person into the appropriate waiver, assures that all requirements of the home and community based waiver will be provided to the person.

Question 10: May someone be discharged from an extended stay at a hospital to MFP?

Answer: No, the discharge must be from a nursing facility, a long-stay hospital or an Intermediate Care Facility for the persons with an Intellectual Disability/Mentally Retarded.

Question 11: How many participants are expected to transition from an institution into the EDCD during the four years of the MFP demonstration project?

Answer: Estimates are 47 persons in year one and 170 persons for each of the following three years.

Question 12: Are there limited slots for EDCD waiver recipients in MFP?

Answer: There are slots outlined in question #11 that has been approved by the Center for Medicare and Medicaid Services for MFP participants in the EDCD waiver. This waiver does not have a waiting list.

Question 13: Are slots in the waiver limited by geographic considerations?

Answer: No, the slots have been approved statewide to ensure that everyone transitioning has similar opportunities.

Question 14: Can an agency contract with private provider to provide Transition Coordination?

Answer: The regulations state that a Transition Coordinator must be employed by the agency which has the Medicaid provider agreement. No, Transition Coordination may not be contracted out unless it is to another agency that has meets all of the requirements and is a Medicaid provider for Transition Coordination

Question 15: How will EDCD Transition Coordination interface with service facilitation?

Answer: There is no change. If the person elects to receive a consumer directed services under a waiver, the Transition Coordinator or case manager will include that in the plan of care, and a service facilitator will be selected by the individual, or the representative – employer of record, and hire, train and supervise the service provider.

Question 16: If an agency wants to be a Transition Coordination agency, what does the agency need to do?

Answer: Check the DMAS website at www.dmas.virginia.gov for a provider enrollment form. Complete the form and submit it to First Health. The application process takes approximately 15 days, provided all of the required documentation is provided by the applicant.

Question 17: If an agency is already a Case Management Medicaid provider do they have to apply to be a Transition Coordination Agency.

Answer: Yes. If the Case Management agency would like to serve a new population, such as Elderly or Disabled with Consumer Direction Waiver participants then they would need to apply to be a Medicaid provider of Transition Coordinator.

Question 18: If a Community Services Board enrolls as a provider for Transition Coordination in order to be able to serve a new population, does each staff person need to enroll or only the agency?

Answer: Only the agency needs to enroll as a Medicaid provider and the staff is covered under that provider agreement for as long as they are employed

Question 19: How will DD waiver be handled, will a Transition Coordinator provide this service?

Answer: The DD waivers will be handled as they are now, with a case manager with DMAS oversight.

Question 20: Who will be available for EDCD and technology assistive waivers when Transition Coordination ends?

Answer: For EDCD, as mentioned earlier, other community agencies, family, will be responsible for coordinating services, along with the individual.

Question 21: What about food stamps and other services. May these be obtained prior to discharge or otherwise expedited?

Answer: We will work with the Department of Social Services in every way possible to accommodate making this a smooth and expedited process.

Transition Service/funding

Transition Service/funding is authorized for nine months and include up to two months while the individual is in an institution and seven months following discharge and include the set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. The service description, criteria, service units and limitation and provider requirements for this services is found in 12VAC 30-120-2010.

Question 22: If a MFP participant chooses to leave a nursing facility and relocate to live with family may the transition services/funding be used in the family member's home.

Answer: Please refer to the definition of transition services/funding. Those services may be used in relocating a participant to an approved home and community based setting including the home of a family member

Question 23: Can transition services/funding be utilized to maintain housing during a hospitalization or a readmittance back to a facility setting.

Answer: No. Transition services/funding, is to be used only for the set up of housing and active transition to a home and community setting.

Question 24: When person is hospitalized is the Transition Coordination responsible for helping with ongoing bill paying/maintain household?

Answer: No. This responsibility would belong to the support group of family, friends, guardian or community in which the participant is located

Question 25: If a participant leaves a facility and then enters a hospital and then back to the community and back to the hospital, for how long may they use their transition services/funding?

Answer: Transition services/funding is authorized only for nine months. Once the nine months have expired they participant no longer has access to this funding.

Question 26: A gap in the program seems to be in the area of set-up costs. For example, utility deposits cannot be paid prior to re-entry to the community and enrollment in a waiver. This will be a barrier to accessing services through MFP.

Answer: MFP has built transition services/funding as a part of the demonstration. The service is authorized for nine months including up to two months while residing in a

facility and seven months following discharge. Utility deposits are an appropriate expense for these funds.

Question 27: As a current DMHMRSAS provider, what would we need to do to provide transition services/funding?

Answer: As a current provider of MR/ID services, there is nothing more that you would need to do in order to serve MR waiver participants through MPF. However, your agency would be required to provide "up-front" funds for transitional service/funding and request reimbursement through Public Partnership LLC for those funds. You will be required to complete a provider enrollment package with PPL which may be obtained by contacting Web site has not been established yet_____.

Question 28: Is transition coordination billed as a monthly rate.

Answer: Yes

Question: What is the reimbursement rate for Transition Coordination?

Answer: $326.50 a month.

Question 29: Transition Coordinator provides upfront costs of $5,000. and then receives the money once invoices are submitted.

Answer: Yes, transition coordination agencies will upfront the transition services/funding and then submit for reimbursement to PPL the DMAS fiscal agent.

Question 30: Please clarify the billing/reimbursement process for transition services/funding. How long will it take?

Answer: Reimbursement for goods and services procured through transition services/funding will be issued within 14 days following submission of appropriate expenditures and information to PPL.

Question 31: I represent a private non-profit. How is an agency like mine able to provide the up-front money for transition services?

Answer: During the planning process, a focus group was used to provide feedback from agencies who will be involved in administering MFP throughout the Commonwealth. At this point, we are working with a reimbursement model. However, over the long-term, we are looking to arrange for some process, through PPL, to allow for on-line purchasing or debit card method, which would make it easier for smaller agencies to procure items and services.

Question 32: This question relates to coordination between authorization and purchase for items. Agencies will not be able to purchase on behalf of an individual for

community re-entry until the individual is discharged from a facility. Some things may need to be arranged and paid for prior to discharge.

Answer: Transition Services/Funding is authorized for nine months with up to two of those months being while the participant resides in the facility prior to discharge. Therefore, appropriate goods and services may be purchased prior to with prior authorization. However, the case manager Transition Coordinator will be key at assessing the appropriateness of enrolling the individual into the waiver upon discharge, and the case manager/transition coordinator who will be working with the individual must concur and authorize these transition purchases.

Question 33: Do the $5,000 transitional services/funding apply to residential services?

Answer: Generally no. However, under MFP, an adult foster home would be a qualifying residence for an individual to receive transitional service/funding through MFP

Question 34: May transition services/funding be used to make repairs to a group home of four or less persons?

Answer: No, the transition services/funding may not be used for this purpose. DMHMRSAS has separate funding for this purpose and should be contacted for further information at ----Requested this information from DMHMRSAS----------.

Question 35: May transition services funding be used for a group home of four or less?

Answer: No.

Question 36: Can Transition Services/Funding be used for sponsored homes in which there are two or fewer persons?

Answer: If individual is contributing towards housing costs then it may be used and it is not providing furnishings or supplies already provided by the sponsored home. EM & AT are available upon enrollment in a waiver. THIS ANSWER NEEDS TO BE CHECKED

Question 37: MFP has a 12 month limit to case management. It sounds like a set-up, to bring people into a community only to have the services end once they are re-established in a community.

Answer: There will be an array of community services that the individual will be able to access by the time that Transition Coordination concludes including several levels of back-up systems for emergencies to assist when there is a breakdown in service delivery. First, each person enrolled in MFP will be enrolled and receiving waiver services and have a designated primary back-up system within the service plan, as a requirement of community re-entry. All of the waiver programs assurances for health and safety will apply to any person enrolled into a HCBS waiver upon discharge. Next, through the 2-1-

1 statewide call center, there will be person available 24 – 7 to assist with information, referral and available to answer questions when needed. Finally, KePRO authorizes services based on the care plan, applies service limits defined within the waiver, and assures that individuals' needs are met. Waiver services require that the individual be able to reside safely in the community is a prerequisite of authorization by the case manager/transition coordinator and KePRO.

Question 38: Who will make the request for Environmental Modification and Assistive Technology under the EDCD waiver after 12 months when the Transition Coordinator is no longer working with the participant?

Answer: The providers of EM and AT may make the request directly to KePro on behalf of the participant or the Service Facilitator under consumer-direction may assist.

Question 39: What about consumer-directed supported employment?

Answer: Due to unresolved concerns over Worker's Compensation issues this is not a part of the initial MFP roll out. However, the service is still actively under study and if issues can be resolved to satisfaction it may be added at a later date.

Question 40: Who is going to supervise the person when they are in the community?

Answer: MFP is similar to the current Medicaid HCBS waivers. The individual must be able to reside safely in the community setting, with appropriate services. We envision that services will be provided collaboratively, across many agencies, to fully support the person's needs in the community. Health and safety are prerequisites to receipt of a waiver and all MFP recipients will receive information on health and safety. Also, informal systems (family, friends, etc.) will be relied upon to provide core services, just as they are now.

Question 41: In the MFP grant, where is the money coming from? Is the money the money that would be spent in a facility, and that money "follows" the person into the community?

Answer: This is the concept of the program. In many states, the system of community based care is less developed than in Virginia. Virginia has been working for many years to shift services from institutional settings to home and community based settings to better serve recipients and meet their preferences. MFP will essentially strengthen the system of home and community based services that are already in place through Medicaid waivers. We hope that MFP will make it a little easier for people to move to home and community settings.

Question 42: People entering MFP must meet nursing facility level of care. These people may be incapacitated. Who makes the decisions?

Answer: There is no difference with MFP than for any other waiver. If there is a responsible person, or guardian that serves as a substitute decision maker, that individual would continue to act on behalf of the individual.

Question 43: Will group homes get MFP participants?

Answer: A group homes is an allowable community-placement residence if the home has 4 or less residents.

Question 44: How is eligibility determined, what is the process?

Answer: The MFP individual must be eligible for Medicaid which is determined by the local departments of social services, and able to reside safely in the community, which will be based on the assessment of the case manager or transition coordinator.

Question 45: Will private providers receive referrals through MFP?

Answer: If private providers are Medicaid enrolled service providers, as allowed by the waiver regulation, yes. There would be no change in the way waiver services are authorized, provided or administered.

Question 46: How will PACE be used?

Answer: The Program of All Inclusive Care for the Elderly (PACE) is a program which includes all acute and long-term care services. If someone transitions from an institutional setting to a qualified community residence in which there is a PACE program and they are meet eligibility requirements, then PACE might be a service option choice for them. Transition service/funding are excluded from PACE, for purposes of MFP.

Question 47: Our jurisdiction has long waiting lists for housing, and other services. It seems like a "set-up" for consumers, offering a service when there are limited community resources.

Answer: We are aware of the affordable housing issues throughout the Commonwealth. This is something that we will all continue to work on across many agencies. MFP affords individual's another option with funding for transition services ($5,000 per lifetime per individual funding) which can include security deposits, first months rent, set-up costs, etc. However, monthly rental or mortgage expenses or ongoing costs such as food or utilities are not allowable costs under transition services.

Question 48: Can you give examples of long-stay hospitals.

Answer: There are two Medicaid long-stay hospitals in the Commonwealth and six in totals that serve children with many critical medical needs. Long-stay hospitals serve

people who would receive skilled care, and may be ventilator dependent. The tech waiver enables these individuals to be at home, close to family while services continue.

Question 49: May a participant under MFP leaves a facility, be enrolled in the Elderly of Disabled with Consumer-Direction Waiver and receive environmental modifications and assistive technology?

Answer: Yes. Both services have been added to the EDCD waiver effective July 1, 2008.

Question 50: Do we have access to a risk assessment tool and if so who is expected to complete this?

Answer: This will be incorporated in the development of a plan of care by the Transition Coordinator or the Case Manager.

Question 51: Once a person transitions from a facility to the MR/ID MR waiver, is slot handled like any other waiver slot?

Answer: Yes, the slot has the same status as other "facility slots." The participant would need to retain the slot for twenty-four months, slot process is the same. [Dawn researching].

Note: *Questions and answers provide the most current interpretation of regulation and policy based on the development of this new program. Our thanks to those asking the questions, and to the collaboration of experts across many fields who have given their time and knowledge to help implement this important program.*